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March 24, 2006

#### By Hand Delivery and Email

Board of Directors Dirigo Health Agency Attn: Lynn C. Theberge 211 Water Street Augusta, ME 04333

Re: Maine State Chamber of Commerce Prehearing Brief

Dear Ms. Theberge:

Enclosed for filing please find two hard copies of the Prehearing Brief of the Maine State Chamber of Commerce.

Thank you for your attention to this matter.

Very truly yours,

William H. Stiles

WHS/rdl Enclosures

cc: Kelly Turner, AAG (By Hand Delivery and Email)
William H. Laubenstein, III, AAG (By Hand Delivery and Email)
James Smith, Esq., Hearing Officer (By Hand Delivery and Email)
Joe Ditré, Esq. (By Hand Delivery and Email)
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#### STATE OF MAINE

#### **DIRIGO HEALTH AGENCY**

IN RE:	)
	)
DETERMINATION OF AGGREGATE	)
MEASURABLE COST SAVINGS FOR	) MAINE STATE CHAMBER
THE SECOND ASSESSMENT YEAR	) OF COMMERCE PRE-
(2007)	) HEARING BRIEF
	)
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Pursuant to Procedural Order No. 3, dated February 22, 2006, the Maine State Chamber of Commerce (the "Chamber"), by and through its attorneys, hereby submits its Pre-Hearing Brief.

#### I. INTRODUCTION.

The Dirigo Health Agency ("Dirigo Health"), through its Board of Directors (the "Board"), published a Notice of Pending Proceeding and Hearing dated January 27, 2006 ("Notice"). As stated in the Notice, "[t]he purpose of the adjudicatory hearing is for the Board to adopt a methodology for the determination of aggregate measurable cost savings, and, using that methodology, determine aggregate measurable cost savings . .." Notice at section 2. The hearing was originally scheduled to begin on March 15, 2006. The hearing date was subsequently rescheduled to March 27, 2005. On March 7, 2006, however, Dirigo Health moved to continue the hearing "to a date after August 1, 2006," and the Board determined that it will not rule on Dirigo Health's motion to continue until March 27, 2006. The Board thus issued a Second Amended Notice of Pending Proceeding and Hearing, notifying parties that the

adjudicatory hearing will start at 9:00AM on March 28, 2006, if Dirigo Health's pending motion to continue is not granted. Meanwhile, the Hearing Officer ruled that all interim deadlines remain in effect. As a result, interested parties must arrange for witness attendance (including flights to Maine), prepare pre-filed testimony and exhibits, and file pre-hearing briefs, all with the prospect that the Board will grant Dirigo Health's motion to continue on the day before the hearing is scheduled to begin.

The Board granted the Chamber's application to intervene as a matter of right. The Chamber's interest in this proceeding is to ensure that Dirigo Health and the Board adopt a reasonable methodology for determining any savings. The Chamber believes that the methodology must reflect the plain language and intent of 24-A M.R.S.A. § 6913, and should produce an accurate measure of savings, without overreaching and overstating savings. Overreaching and overstating savings only serves to convert the savings offset payment (SOP) into a health care tax on Maine businesses that provide health insurance to their employees. The Chamber had hoped that Dirigo Health and the Board would adopt a procedure which would be open and fair to all parties, and provide the opportunity to meaningfully participate in the proceeding to ensure that the methodology offered by Dirigo Health is sound. Unfortunately, this did not happen.

The Chamber has already voiced its due process concerns with the procedure set forth by the Board, and will not repeat those concerns here in their entirety, except to reiterate that the Chamber's ability to determine whether Dirigo Health's proposed methodology (1) reflects the plain language of 24-A M.R.S.A. § 6913 and (2) produces an accurate measure of savings has been all but blocked by Dirigo Health's failure and refusal to provide information concerning its

See the Maine State Chamber of Commerce Application to Intervene and Objection to Provisions in the Notice and Draft Procedural Order at section III, the Maine State Chamber of Commerce Identification of Alternative Methodology and Supporting Data at section I, and the Maine State Chamber of Commerce Witness and Document Designation, Including Rule 26 Disclosures, at section I. The Chamber hereby incorporates herein the referenced arguments and objections.

proposed methodology, failure and refusal to entertain any discovery under the APA, failure and refusal to comply with information disclosure deadlines set forth in Procedural Order No. 3, and failure or refusal to fully respond to Freedom of Access Act ("FOAA") requests, by relying in part on a somewhat interesting interpretation of its obligations under FOAA.

Although Dirigo Health provided an outline of its proposed methodology after specifically ordered to by the Hearing Officer, the outline was provided on the evening of March 20, just 48 hours before pre-filed testimony was due. See Exhibit A attached hereto and hereinafter referred to as the "Proposed Year 2 Methodology." Moreover, the Proposed Year 2 Methodology is bereft of any actual calculations, instead describing the methodology in vague and general terms subject to varying interpretation. Even more telling, page 9 of the Proposed Year 2 Methodology contains the following statement:

The methodologies for cost savings that are presented here have been developed in the absence of much of the necessary data. As a result, the final methodologies may require some adjustments when the final data is utilized.

Thus, Dirigo Health's proposed methodology for determining Year 2 savings is not only vague and unclear, but likely will change in light of "the final data utilized." As a result, the Chamber reserves its right to supplement written argument and testimony if and when Dirigo Health discloses its methodology and provides interested parties with the actual calculations it will use to determine Year 2 savings.

#### II. APPLICABLE LAW.

The statutory provisions governing this proceeding are found at 24-A M.R.S.A. § 6913. It reads, in pertinent part, as follows:

After an opportunity for a hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually not later than April 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased

MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

<u>Id</u>. By its plain language, this provision requires that savings be "aggregate," "measurable," and "as a result of" (1) "the operation of Dirigo Health" and (2) "an expansion in MaineCare eligibility occurring after June 30, 2004."

## III. THE PROPOSED YEAR 2 METHODOLOGY IDENTIFIES POTENTIAL SAVINGS THAT ARE NOT CONTEMPLATED BY THE PLAIN LANGUAGE OF 24-A M.R.S.A. § 6913

The Proposed Year 2 Methodology identifies four so-called "Initiatives for Cost Savings measurement," including Hospital Savings Initiatives, Uninsured Savings Initiatives, Certificate of Need ("CON") and Capital Investment Fund ("CIF") Savings Initiatives, and Health Care Provider Fee Savings Initiatives, all with their various components. See Proposed Year 2 Methodology at page 7 and 8. The Chamber's position with respect to the permissible scope of savings is simple: The only methodology permitted by the plain language of 24-A M.R.S.A. § 6913(1)(A), is one that interprets "aggregate measurable cost savings" to mean savings that are reductions to bad debt and charity care costs as a result of:

(1) The operation of Dirigo Health, and

(2)

of 24-A M.R.S.A. § 6913(1)(A).

24-A M.R.S.A. § 6913(1)(A). The Chamber contends that a measurement of the reduction in bad debt and charity care costs (as described above) is the only measurement properly before the Board at this hearing. As explained below, all other purported cost savings are beyond the scope

Any expansion in MaineCare eligibility occurring after June 30, 2004.

#### A. Legal Standard for Statutory Construction.

The main objective in statutory interpretation "is to give effect to the Legislature's intent." First Union Nat'l Bank, 2005 ME 108, ¶ 8, 882 A.2d at 798 (citing City of Bangor v. Penobscot County, 2005 ME 35, ¶ 9, 868 A.2d 177, 180); see also Labbe v. Nissen Corp., 404

A.2d 564, 567 (Me. 1979) (stating: "The determination of legislative intent is the fundamental rule in the interpretation of a statute."). When seeking the Legislature's intent, we must first look to the language of the statute itself. <u>Labbe</u>, 404 A.2d at 567; David John Kennedy, *Statutory Construction in Maine*, 7 Me. Bar J. 148, 150 (1992). If the statute is unambiguous, we must give the language its plain meaning. <u>First Union Nat'l Bank</u>, 2005 ME 108, ¶ 8, 882 A.2d at 798.

Additionally, the whole statutory scheme for which the section at issue forms a part must be considered so that "a harmonious result, presumably the intent of the Legislature, may be achieved." Id. (citing City of Bangor, 2005 ME 35, ¶ 9, 868 A.2d at 180). In doing so, nothing in a statute is "treated as surplusage if a reasonable construction supplying meaning and force is otherwise possible." City of Bangor, 2005 ME 35, ¶ 9, 868 A.2d at 180 (quoting Labbe, 404 A.2d at 567). Furthermore, statutory language will not be construed to effect absurd, illogical, or inconsistent results. Kimball v. Land Use Regulation Com'n, 2000 ME 20, ¶ 18, 745 A.2d 387, 392. Finally, if there is any ambiguity, then we may look beyond the statute to extrinsic sources such as the statute's legislative history or other external indicia of legislative intent. Irving Pulp & Paper, Ltd. v. State Tax Assessor, 2005 ME 96, ¶ 8, 879 A.2d 15, 18.

## B. The Plain Language of the Statute Limits the Meaning of Aggregate Measurable Cost Savings.

At issue is the meaning of "aggregate measurable cost savings." Although this term is not defined by the statute, its meaning is made clear by applying the required rules of statutory construction.

## (1) Savings Must Result from the Operation of Dirigo Health and an Expansion in MaineCare Eligibility.

The plain meaning of "aggregate" is "a mass or body of units or parts somewhat loosely associated with one another; the whole sum or amount." Webster's 3<sup>rd</sup> New International

Dictionary (2002). In order for the word "aggregate" to be given force and effect and not treated as surplusage, the phrases that follow it must be the identifiable and measurable parts that are included in an overall amount. In other words, aggregate measurable costs savings must be comprised of the following parts: savings as a result of (1) the operation of Dirigo Health, and (2) an expansion in MaineCare eligibility after June 30, 2004. Otherwise, the Dirigo Board would be able to include *any* cost savings experienced in the State of Maine -- whether or not related to healthcare costs. This would lead to an absurd and illogical result, and would be inconsistent with the section's placement in the "Dirigo Health Act." 24-A M.R.S.A. § 6901.

The use of the inflected form of the transitive verb "including" in the statute also supports this reading. "Including" means "to take in or comprise as a part of a whole." Webster's 3<sup>rd</sup> New International Dictionary (2002). Here, the aggregate measurable cost savings takes in or includes savings, such as bad debt and charity care, that are the result of the operation of Dirigo Health and an expansion in MaineCare eligibility. Since nothing in a statute may be treated as surplusage if a reasonable construction giving each word meaning and force is possible, City of Bangor, 2005 ME 35, ¶ 9, 868 A.2d at 180, "aggregate measurable cost savings" must be limited to those savings in the nature of a reduction or avoidance of bad debt and charity costs that are the result of the operation of Dirigo Health and an expansion in Maine Care eligibility. To conclude otherwise would render the statutory terms "as a result of" meaningless, and provide no limitation whatsoever on the term "aggregate measurable cost savings." Certainly, if the Legislature intended the term "aggregate measurable cost savings" to be limitless, it would have used the phrase "including, but not limited to" as it did in another section of the same statutory scheme. 24-A M.R.S.A. § 6908(7) ("Other state agencies, including, but not limited to, the bureau ... shall provide technical assistance and expertise to Dirigo Health upon request.") (emphasis added).

Application of the familiar ejusdem generis rule of statutory construction provides additional support for the interpretation identified above. According to this rule, "a general term followed by a list of illustrations is ordinarily assumed to embrace only concepts similar to those illustrations." Penobscot Nation v. Stilphen, 461 A.2d 478, 489 (Me. 1983) (concluding that the statutory term "internal tribal matter" embraced only those matters illustratively listed in the statute and other matters like them and holding that the statutory term did not include beano games); In re Roberts, 22 B.R. 215, 217 (Bankr. D. Me. 1982) (quoting United States v. Insco. 496 F.2d 204, 206 (5th Cir. 1974) (noting that "general and specific words, when present together, are associated with and take color from each other.")). Here, the term "aggregate measurable cost savings" is followed by a listing of types of savings: "any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility." 24-A. M.S.R.A. § 6913(1)(A). Thus, according to the rule of ejusdem generis, "aggregate measurable cost savings" is limited to specific savings, like bad debt and charity care, that result from the operation of Dirigo Health and an expansion in MaineCare eligibility.<sup>2</sup>

Significantly, Dirigo Health's own parsing of the plain language of § 6913(1) has produced a similar conclusion. Indeed, in the Board's filing with the Superintendent of Insurance for the First Assessment Year, the Board states in the cover letter: "The Act tasked the ... [Dirigo Board] with annually determining the aggregate measurable cost savings as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility." (emphasis added).

Assuming that there is no specified limit on the calculation of "aggregate measurable cost savings," then the Legislature has impermissibly delegated its taxing authority to Dirigo Health and the Board. Indeed, Dirigo Health and its Board would have nearly unfettered authority to set a tax in the form of the SOP assessment.

#### (2) The Meaning of Dirigo Health.

The use of the phrase "the operation of Dirigo Health" provides additional insight regarding the Legislature's intent. The term "Dirigo Health" is defined in 24-A M.R.S.A. § 6902 as "an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents on a voluntary basis." Dirigo Health is "also responsible for monitoring and improving the quality of health care in this State" through the Maine Quality forum. Id.; see 24-A M.R.S.A. § 6951. Because the Legislature has also defined the term "Dirigo Health Act" as chapter 87 of Title 24-A (24-A M.R.S.A. §§ 6901-6971), the use of these different terms within the same statutory scheme effectively rules out any intention of the Legislature to capture cost savings as a result of the Dirigo Health Act generally, or as a result of Chapter 469. Since the Hospital Savings Initiatives, CON and CIF Savings Initiatives, and Health Care Provider Fee Savings Initiatives are not under the jurisdiction of Dirigo Health, they are not properly included as savings resulting from the operation of Dirigo Health, nor are they the result of a MaineCare expansion after June 30, 2004.

### (3) The Entire Statutory Scheme Also Evidences the Legislature's Intent to Limit the Scope of Aggregate Measurable Cost Savings.

An interpretation of "aggregate measurable cost savings" that limits savings to those in the nature of a reduction in bad debt and charity care cost resulting from the operation of Dirigo Health and an expansion in MaineCare eligibility is further supported by and reflected in the entire statutory scheme. For example, another subsection of the statute requires health insurance carriers and health care providers:

[T]o demonstrate and report that they have used their best efforts to obtain savings offset payments through negotiated reimbursement rates that reflect the provider's reductions or stabilization in the cost of bad debt and charity care as a result of the

<sup>&</sup>lt;sup>3</sup> 24-A M.R.S.A. § 6901.

operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24 M.R.S.A. § 6913(7) (Supp. 2005) (emphasis added). Likewise, Section 6913(7)(B) states that health care providers, when engaged in contract negotiations with carriers, "shall provide data relating to any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as a result of the operation of Dirigo Health and as a result of any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." Id. (emphasis added). Similarly, 24-A MRSA § 6913(8)(C) requires health insurance carriers and health care providers to:

[R]eport annually . . . information regarding the experience of a prior 12-month period on the efforts undertaken by the carrier and provider to recover savings offset payments, as reflected in reimbursement rates, through a reduction or stabilization in bad debt and charity care costs as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

If the Legislature intended to define the term "aggregate measurable cost savings" more broadly, then it certainly would not have limited the carriers' and health care providers' reporting obligations to bad debt and charity care saving resulting from the operation of Dirigo Health and an expansion in MaineCare eligibility. Indeed, it would have specified additional reports related to voluntary cost and operating margin limitations, the CON moratorium, and MaineCare budget decisions.

#### (4) <u>Summary</u>.

The plain language of the statute interpreted in accordance with the accepted canons of statutory construction unambiguously defines "aggregate measurable cost savings" to mean savings in the nature of reductions to bad debt and charity care costs as a result of:

- (1) The operation of Dirigo Health, and
- (2) An expansion in MaineCare eligibility occurring after June 30, 2004.

Therefore, these are the only sources of savings that the Board may properly consider.

## C. The Plain Language of the Statute Does Not Support the Hospital Savings Initiative, CON and CIF Savings Initiatives, and Health Care Provider Fee Initiatives

#### (1) <u>Hospital Savings Initiative</u>.

For the First Assessment Year, the Board asserted that the hospital savings arose from the voluntary limitations specified in Section F-1(B) of Chapter 469,<sup>4</sup> which read as follows:

B. Each hospital ... is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than 3.5% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004. Each hospital is asked to voluntarily hold hospital consolidated operating margins to no more than 3% for the hospital's fiscal year beginning July 1, 2003 and ending June 30, 2004.

Id. This unallocated language does not apply to the Second Assessment Year, and there are no other statutory limits, voluntary or otherwise, relating to CMAD or COM for the Second Assessment Year. Undaunted, Dirigo Health points to a newsletter from the Maine Hospital Association ("MHA") as support for its Hospital Savings Initiative. See Proposed Year 2 Methodology at page 2. The assertion that a newsletter from the MHA is "as a result of the operation of Dirigo Health" does not pass the straight face test, and is not a valid basis for attributing any savings to Dirigo Health. In fact, even before the existence of Dirigo, as part of what was called the "Maine Health Care Challenge," a number of health care organizations and professionals agreed to limit their operating margins. Dirigo Health cannot take credit for, and then base a tax on, every single health care initiative in Maine simply by virtue of the agency's existence.

Even assuming the MHA newsletter can somehow be ascribed to Dirigo Health, and even assuming all of the MHA's members agree to comply with the representations in the newsletter,

P.L. 2003, c. 469.

In essence, Dirigo adopted the Maine Health Care Challenge. <u>See</u> additional documents filed by the Chamber at No. 21, page 59.

it does not follow that a hospital's attempt to comply with a 4.5% limit on cost increases per CMAD would produce "savings" to be measured under 24-A M.R.S.A. § 6913(1). Indeed, the plain language of Section 6913 refers to savings "as a result of the operations of Dirigo Health" - not as a result of the operations of the MHA. Dirigo Health was established "to arrange for the provision of comprehensive, affordable health care coverage ...." 24-A M.R.S.A. § 6902. The powers and duties delegated by law to Dirigo Health reflect this purpose, and do not include monitoring or enforcing the voluntary limits on hospitals or other persons or entities like the MHA. 24-A M.R.S.A. § 6908 (specifying the powers and duties of Dirigo Health). Finally, voluntary cost limits are not in the nature of a reduction of bad debt and charity care costs, as required by the plan language of Section 6913(1). They are simply voluntary cost containment measures by hospitals. Therefore, the Chamber objects to the inclusion in "aggregate measurable cost savings" of any amount related to the Hospital Savings Initiatives.

#### (2) Health Care Provider Fee Initiatives.

The Proposed Year 2 Methodology contains a savings initiative entitled "Health Care Provider Fee Savings Initiatives," and conveniently includes the statement:

The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives.

<u>See</u> Proposed Year 2 Methodology at page 5. Last year Dirigo Health justified its use of Medicaid <u>payments</u> as a measure of cost savings because Chapter 469 created the Commission to Study Maine Hospitals ("Commission"), and the Commission's Report ("Report") happened to mention various longstanding problems with hospital and physician Medicaid funding in a section explaining "cost shifting." It appears that Dirigo Health will adopt a similar approach this year. While creative, this attenuated connection does not satisfy the plain language of

On this same basis, the Chamber objects to consideration of the CON/CIF Savings Initiatives. The responsibility for administering the CON laws and regulations rests with the Department of Health and Human Services, not Dirigo Health.

Section 6913. Again, the law requires savings "as a result of the operations of <u>Dirigo Health</u>" -- not as a result of the <u>Dirigo Act</u>, the <u>Commission</u>, or <u>Chapter 469</u>.

Moreover, neither Dirigo Health nor the Commission has the authority to administer the MaineCare program. Indeed, pursuant to the MaineCare State Plan (a document required by the federal government), the Office of MaineCare Services ("OMS") in the Department of Health and Human Services is the single state agency authorized to administer the MaineCare program. Thus, any alleged "savings" cannot be the result of the operation of Dirigo Health. Further, even assuming that Dirigo Health can bootstrap MaineCare payments into Dirigo Health "savings," there is no basis for concluding that long overdue <u>payments</u> represent "<u>cost</u> savings." Therefore, the Chamber objects to the inclusion in "aggregate measurable cost savings" of any amount related to the Health Care Provider Fee Savings Initiatives.

D. The Legislative History of the Statute Does Not Support the Hospital Savings Initiative, CON and CIF Savings Initiatives, and Health Care Provider Fee Initiatives

The Legislative intent is clear from the plain language of 24-A M.R.S.A. § 6913(1)(A). Aggregate measurable cost savings is intended to be a measure of any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of:

- (1) The operation of Dirigo Health, and
- (2) Any increase in MaineCare enrollment due to an expansion in MaineCare eligibility.

Dirigo Health's broad reading, as reflected in the Proposed Year 2 Methodology, goes far beyond measuring reductions in bad debt and charity care, and attempts to credit Dirigo Health with purported savings generated by completely separate and independent government initiatives

If Dirigo Health is permitted to include these payments as savings, then the savings should be offset by the increased cost caused by MaineCare's continued refusal to reasonably estimate PIP payments and timely settle MaineCare cost reports. According to Dirigo Health, this also must be as a result of the operation of Dirigo Health as noted in the Hospital Commission Report.

in the field of healthcare. This is contrary to the plain and unambiguous language of § 6913(1)(A). However, even assuming some ambiguity exists, the legislative history is replete with testimony, statements, and comments which demonstrate that reductions in bad debt and charity care were intended to be the <u>only</u> basis for computing aggregate measurable cost savings and the resultant tax on health care claims.

For example, at a May 15, 2003 public hearing before the Joint Select Committee on Health Care Reform ("Joint Select Committee"), a representative of the Governor's Office of Health Policy and Finance testified as follows with regard to L.D. 1611:

Those uninsured citizens seek care only when no other option is available – at late and costly stages of disease. Hospitals and other providers care for them at no charge, then raise their rates to cover the losses associated with that care. Those increased rates are charged to insurance premiums in the form of a cost shift that all of us pay. As a result, there is today \$275 million already in the system that covers bad debt and charity care to pay for the uninsured when they get sick. We propose to reinvest less than a third of that money to help pay for health insurance coverage including coverage for prevention and primary care, for all Maine's uninsured. This will provide a payment source for health care services and avert the need to shift charity care costs to others. We propose recapturing those funds through an assessment of 4.0% on the gross revenues of insurance companies, which could not be passed on to consumers. Again, it [bad debt and charity care] is money already in the system and therefore, despite assertions to the contrary, premiums will not be allowed to increase when we recover those costs.

<u>See</u> Testimony of Trish Riley, Director, Governor's Office of Health Policy and Finance, Before the Joint Select Committee on Health Reform, May 15, 2003, (emphasis added) included with additional documents filed by the Chamber at No. 11. Likewise, at the same public hearing Honorable Senator Sharon Treat, Senate Majority Leader and Lead Senate sponsor of L.D. 1611, testified as follows on the issue of financing Dirigo Health:

Specifically, the [Dirigo] plan pools a variety of resources, relying on:

Insurance companies who will pay "up front" for less expensive preventative health care, rather than the more expensive "bad debt and charity care" frequently provided to the uninsured and underinsured in hospitals.

Testimony of Sharon Anglin Treat, Senate Majority Leader, to the Joint Select Committee on Health Care Reform, May 15, 2003, (emphasis added), included with additional documents filed by the Chamber at No. 11. This testimony, on behalf of the Dirigo Health agency and by the bill's lead sponsor, is unequivocal; bad debt and charity care was intended to be the only basis for determining aggregate measurable cost savings.

Additional support for the above conclusion is found in answers to questions posed by the Joint Select Committee, which were submitted by the Governor's Office of Health Policy and Finance about a week after the May 15, 2003 public hearing. See Responses to Committee Questions--Governor's Office of Health Policy & Finance, included with additional documents filed by the Chamber at No. 11. Indeed, the very first question posed is:

Why is the proposal funded solely from a tax on insurers and not a broader funding mechanism?

And the answer begins:

The purpose of the assessment is to recover bad debt and charity care now implicit in the prices [for health care services].

The answer goes on to justify the tax on the basis that "the reimbursement rates paid by insurers will not incorporate the cost of bad debt and charity care, but the premiums paid by rate payers will, resulting in a potential windfall to insurers ...." Throughout this document there are repeated references to bad debt and charity care as the only basis for aggregate measurable cost savings and the resultant SOP assessment.

Yet another example illustrating the original intent is a handout from the Governor's Office of Health Policy and Finance, dated June 11, 2003. This handout coincides with upcoming floor debate, and states with respect to the financing of Dirigo Health:

Capture realized savings from the reduction in bad debt and charity care through the savings offset payments . . .. Payments will be made by insurers to Dirigo Health only after savings are shown.

See handout from the Governor's Office of Health Policy and Finance, dated June 11, 2003, (emphasis added), included with additional documents filed by the Chamber at No. 11. As explained by this handout, the testimony before the Joint Select Committee, and the written answers to the Joint Select Committee's questions, the financing of Dirigo Health was intended to be directly connected with, and thus limited to, reductions in bad debt and charity care. To use Dirigo Health's own words, the funds that are to be "captured," must be "realized savings from the reduction in bad debt and charity care." Id. The reduction may be (1) as a result of the operation of the Dirigo Health insurance product or (2) as a result of expansions in MaineCare coverage. Nowhere in the testimony before the Joint Select Committee, written answers to the Joint Select Committee questions, or the June 11, 2003 handout from the Governor's Office of Health Policy and Finance, however, does it mention financing Dirigo Health via other initiatives, completely independent of and unrelated to reductions in bad debt and charity care.8 It only stands to reason that if the intent was for Dirigo Health to be funded almost entirely by initiatives wholly separate and distinct from those aimed at reducing bad debt and charity care, then this would have been explained or at least mentioned in the statute or legislative history. Tellingly, there is nothing in the statute or legislative history to support Dirigo Health's interpretation and, in fact, Dirigo Health's interpretation is contrary to the plain language and legislative history of 24-A M.R.S.A. § 6913(1)(A).

The Chamber could go on for pages citing the various documents that, from the inception of Dirigo Health, would demonstrate to any objective reader that bad debt and charity care reductions were to be the only basis for the savings offset payment. By way of another example, a narrative dated May 5, 2003, states repeatedly throughout that reductions in bad debt and charity care will fund Dirigo Health. No other "savings" initiatives are mentioned. See narrative, included with additional documents filed by the Chamber at No. 21, pages 20, 26, 27, 30, etc. Interestingly, at page 57 of the narrative, bad debt and charity care is described as representing a "substantial indirect, hidden tax on health insurance premiums and costs to fully and self-insured health plans in the state as well as those persons paying out of pocket for their own care." The Chamber submits that this is exactly what the SOP has become as a result of basing it on purported savings that have nothing to do with bad debt and charity care reductions.

Lest there be any remaining doubt, numerous statements made by legislators during floor debate further demonstrate the Legislature's intent for Dirigo Health to be funded only by measurable reductions in bad debt and charity care. For example, during debate of the original bill, Representative Glynn stated:

I did want to explain a little bit about [how] the savings offset premium payments work and how the assessment is going to be made. Essentially the way the offset payments are going to be assessed is that when folks sign up for Dirigo it is anticipated that there is going to be a reduction in bad debt and charity care at doctor's offices and hospitals. Those savings are expected to be in a large amount of money. Those savings are expected to be reflected in reductions and rates at hospitals and at doctor's offices. It is then expected that because the savings are reduced at doctor's offices and hospitals that that savings in turn is going to be passed onto the insurance carriers, which, in turn, will ultimately be passed on to the businesses and also passed onto the consumer.

However, which is important, is the tax that will be assessed (sic) up to that maximum cap will never be greater than the bad debt and charity care that are actually going to be realized by both the hospitals and doctor's offices, that is then realized by the insurance carriers, which then will offset that tax.

<u>Legis</u>. <u>Rec</u>. H-985 (1st. Reg. Sess. 2003) (Statement of Rep. Glynn) (emphasis added), included with additional documents filed by the Chamber at No. 11.

Unfortunately, DirigoChoice enrollment fell well short of projections, and the savings related to reductions in bad debt and charity care, which were expected to be a large amount of money, were in fact about \$2.7 million. This is not enough to sustain Dirigo Health. As a result, recent amendments to Section 6913, although not altering any of the language at issue, caused additional debate on the scope of aggregate measurable cost savings because, by this time, Dirigo Health knew it could not identify sufficient savings from bad debt and charity care alone to sustain the agency and its insurance product. Knowing this, Dirigo Health apparently indicated that it intended to expand, without authority, the scope of measurable savings for the First Assessment Year to include other, independent government initiatives relating to health care in Maine. For example, Senator Mills noted:

One of the answers (sic) that we will try to make is that we are saving the money through other things that Dirigo is doing. The original theory of the Dirigo product was that by taking people off the uninsured list and giving them insurance that this would save on bad debt and charity care. I have no doubt that there will be some small measure of savings arising from the sale of this product to people who are uninsured. I believe that this savings will be miniscule. Because it is miniscule, I understand that the directors of Dirigo plan to take credit for, and maybe they should, other initiatives of the Dirigo program in a broader context. One of the awkward things in our discussion is that the Dirigo label is used not just for the health product, which is one initiative, but also for a whole set of government initiatives in the field of healthcare; the new controls over certificate of need, the efforts to gain control over hospital costs, and to gain voluntary compliance to limits on the growth in healthcare expenses. All of those things are initiatives of government that could have taken place, and indeed have taken place, in a fashion that is completely independent of the sale of the Dirigo Health product. In an effort to justify the savings to the healthcare system globally or as a whole, the product which benefits a comparatively few people will be subsidized by savings that are generated through the activity of government more broadly and savings that could have redounded to the benefit of the private sector without the sale of the product.

<u>Legis. Rec.</u> S-1238 (1<sup>st</sup> Spec. Sess. 2005) (Statement of Sen. Mills) (emphasis added), included with additional documents filed by the Chamber at No. 11. In response to this statement recognizing the agency's representations, other Senators reiterated the clear and unambiguous intent of the statute as it was enacted. Senator Mayo stated:

It was my understanding two years ago, and it is still my understanding this afternoon, that this 4% savings off-set payment is tied to charity care and bad debt, and that if charity care and bad debts are not reduced on the part of the hospitals, doctors, and etcetera, then we do not have, under current statute, the ability to impose the savings off-set payment because the two were tied together.

<u>Legis</u>. <u>Rec</u>. S-1239 (1<sup>st</sup> Spec. Sess. 2005) (Statement of Sen. Mayo), included with additional documents filed by the Chamber at No. 11. Similarly, Senator Turner stated:

[T]here is the savings off-set payment which the Senators from Sagadahoc, Senator Mayo, and Somerset, Senator Mills, have talked about. This was tied to bad debt and charity care. Our expectation was that if that was documented and validated then by gosh we should capture that because this effort under Dirigo has made that come to pass. I don't want to put words into the Senator from Sagadahoc, Senator Mayo's mouth, but I think he said the payments are, perhaps, miniscule and that may have been attributed to the Senator from Somerset, Senator Mills, but it was in the ether here this afternoon. The fact is we do not have anything to hang our hat on with respect to the savings off-set payment. We

don't know whether that piece works but we do know we have a savings off-set payment calculation that is calculated on nothing at this point in time.

<u>Legis</u>. <u>Rec</u>. S-1240 (1<sup>st</sup> Spec. Sess. 2005) (Statement of Sen. Turner), included with additional documents filed by the Chamber at No. 11.

Thus, despite the understandable efforts by Dirigo Health to maintain the very existence of the Dirigo Health agency and the Dirigo Health insurance product by expanding the measure of aggregate measurable cost savings through administrative fiat, the inescapable conclusion gleaned from reviewing the legislative history of § 6913 is that reductions in bad debt and charity care are the only basis for measuring aggregate measurable cost savings. The separate and independent initiatives in the Dirigo Legislation, such as controls over certificate of need, the voluntary limit on hospital operating margin, etc., were never intended to be measures of aggregate measurable cost savings. On the contrary, as noted in answers to the Joint Select Committee, these independent initiatives were intended simply to benefit Dirigo and other insurance plans generally, "as part of a comprehensive systems improvement." See Responses to Committee Questions--Governor's Office of Health Policy & Finance at answer to question No. 4 (stating with respect to the separate initiatives: "Dirigo, like other insurance plans, will benefit from the impact cost containment exercises on the system"), included with additional documents filed by the Chamber at No. 11. In sum, although understandable in light of Dirigo Health's less than favorable financial prognosis, Dirigo Health's efforts to expand the scope of aggregate measurable cost savings in order to save the agency and its insurance product are contrary to the plain language and legislative history of 24-A M.R.S.A. § 6913(1)(A), and in fact result in a true health care tax--which was never the intent.

## IV. EVEN ASSUMING THE SAVINGS INITIATIVES IDENTIFIED IN THE PROPOSED YEAR 2 METHODOLOGY MAY BE CONSIDERED FOR SAVINGS, THE PROPOSED METHODOLOGY IS UNREASONABLE

As noted above, the Proposed Year 2 Methodology describes methodologies in a general nature, and includes no actual calculations. Therefore, the Chamber is unable to determine exactly what the proposed methodology is, and therefore reserves the right to provide additional argument and analysis once Dirigo Health discloses the actual calculations. Nevertheless, the Chamber offers the following.

#### A. Hospital Savings Initiatives.

The Proposed Year 2 Methodology for calculating CMAD appears to alter the formula from last year. The Chamber notes that there is no indication that Mercer's revised approach will go beyond simply offsetting savings against cost increases on an aggregate basis. Thus, the calculation still simply manipulates raw data, with no analyses to separate the Dirigo savings (if present) from other factors and trends affecting hospital finances, and other cost containment efforts implemented by employers in the state. This approach, like last year's, simply measures random fluctuations from year to year, albeit on an aggregate, statewide level. Similar to last year, this is not a reliable measure of any savings as a result of the operation of Dirigo Health.

Further, even assuming CMAD is a proper savings initiative, without a concomitant limitation on operation margin, there is absolutely no basis to conclude that hospitals can pass the savings on through the system. What is to prevent hospitals from simply keeping the savings, especially in light of recent MaineCare payment cuts? Simply put, without limits on COM, there can be no measured savings for CMAD.

Lastly, Mercer's CMAD calculation fails to recognize that any savings accrue to <u>all</u> health care payors, including MaineCare and Medicare. The CMAD methodology is flawed and

invalid because it assumes that all of the savings have accrued to private payors, when that is not the case.

#### B. Uninsured Savings Initiatives.

Pursuant to the Dirigo legislation, Dirigo Health is directed to measure savings related to any reduction or avoidance of bad debt and charity care costs ("BD/CC") to health care providers as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. § 6913(1). The Proposed Year 2 Methodology sets forth five components for the Uninsured Savings Initiatives, including uninsured reduction in bad debt and charity care, under-insured reduction in bad debt and charity care, MaineCare eligibility enrollment, MaineCare increased enrollment, and uninsured private woodwork enrollment.

Again, from the description provided in the Proposed Year 2 Methodology, it is not entirely clear how Mercer intends to make these calculations. Assuming similar methods and assumptions as last year, the Chamber asserts that Mercer's methodology is highly theoretical, with multiple assumptions that cannot be verified. Despite the ready availability of data from reliable (governmental) sources to measure what actually happened to BD/CC costs, Dirigo Health apparently will not compare its results to the reported uncompensated care data for providers to measure or confirm their presumption that uncompensated care costs were reduced. Employing a highly theoretical method without any analysis of available data on what actually happened is unreasonable.

#### C. CON and CIF Savings Initiatives.

From the description provided in the Proposed Year 2 Methodology, it is not entirely clear how Mercer intends to make the CON/CIF savings calculation. The Chamber reserves its right to supplement written argument and testimony if and when Dirigo Health discloses its

methodology and provides interested parties with the actual CON/CIF calculations it will use to determine Year 2 savings.

Nevertheless, the Chamber points out that Dirigo Health's powers and duties do not include regulating CON matters; instead, such matters are within the purview of the Maine Department of Health and Human Services. 22 M.R.S.A. § 326; 10-144 CMR ch. 503. Thus, any "savings" related to CON cannot possibly be attributed to the operation of Dirigo Health. This conclusion is consistent with the legislative history of Dirigo as explained above, as well as pronouncement's from the Governor's Office of Health Policy and Finance.

#### D. Health Care Provider Initiatives.

It appears that once again Dirigo Health will calculate "savings" related to the Maine Department of Health and Human Services' decision to (1) pay hospitals what they are owed for treating MaineCare patients and (2) increase <u>MaineCare</u> physician fee schedule payments. This methodology is not reasonable.

Even assuming that Dirigo Health can bootstrap MaineCare payments into Dirigo Health "savings," Dirigo Health has offered no explanation for its conclusion that the time value of payments to be made in the future have already resulted in present "measurable cost savings." Furthermore, to the extent that the DHA is relying on the time value of money, it must prove that each of the hospitals in fact saved an expense by receiving payments to which it is legally entitled. Moreover, if the DHA is going to assume that there are cost savings related to these payments, it must also take into account the costs to hospitals of the understated periodic interim payments ("PIP") and the continued delays in interim settlements. Finally, the DHA must provide evidence that the hospitals are in a position to lower charges as a result of these increased (but still substantially understated) PIP amounts, taking into account all factors to be considered by hospitals when setting prices. See Pre-Filed Testimony of Roland Mercier.

Including the physician fee increase in "savings" is illogical. The basis for including fee increases as "savings" appears to be that the Dirigo legislation created the Commission to Study Maine's Hospitals, the Commission's Report to the Legislature (not Dirigo Health) recommended the correction of long-standing (and well known) Medicaid payment shortfalls and delays to hospitals in an effort to reduce cost-shifting. However, the basis for the recommendation for physician fee increases was not cost-shifting. Instead, the Commission Report noted that a physician fee increase was required to ensure patient access. The Commission explained that the lack of a fee increase to physicians since 1983 "affect[s] hospitals which are often required to provide care to Medicaid patients because doctors cannot afford to service the individuals." Commission Report, p. 62. Including the physician fee increase in aggregate measurable cost savings means that this amount will be included in the SOP. Health insurance carriers and TPAs will be forced to pass this SOP to consumers unless they are able to negotiate reduced payments to these physician (dollar for dollar). However, if a physician has to give the long awaited Medicaid fee increase to the carriers and TPAs (who in turn must turn it over to the DHA in the form of an SOP), the physician will be in the exact same financial position as before the Medicaid fee increase -- and still unable to afford treating Medicaid patient. As the Commission recognized, this will add costs to the hospitals.

Furthermore, as explained by Anthem's witnesses in hearings for the First Assessment Year, Medicare, Medicaid and most commercial payers make payments to physicians based upon a fixed fee schedule, and therefore a reduction to a physician's charges would not have the effect assumed by Dirigo Health and Mercer.

Finally, the DHA has presented no evidence that the physician can afford to pass along the full amount of the fee increase, or explained why the physicians should not be permitted to keep these long-overdue payment increases.

E. General Objections.

In addition to the specific objections identified above, the Chamber believes that all

alleged savings should be measured in accordance with the same annual time period. The second

assessment year should address "savings" from July 1, 2004 to June 30, 2005. Furthermore, the

Chamber contends that the DHA may not go back to try to collect "savings" from the first

assessment year because it had the opportunity to measure those savings in the first assessment

year, but failed to produce "reasonable" methodologies. To allow the DHA a second bite at the

apple would violate due process and disregard the statutory term "annually."

V. CONCLUSION

Dirigo Health's Proposed Year 2 Methodology is unreasonable and must be rejected

(1) it includes matters not related to Dirigo Health; (2) it includes flawed because:

methodologies that do not distinguish between naturally occurring fluctuation in CMAD; and (3)

it relies upon unsupported and unsupportable assumptions. The DHA must limit aggregate

measurable cost savings as set forth in the Chamber's Identification of Alternative Methodology

dated March 13, 2006.

Dated: March 24, 2006

Respectfully submitted,

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### Report to the Dirigo Health Agency

# Dirigo Health Savings Offset Payment:

Year 2 — Methodology and Data Sources

**MERCER** 

Government Human Services Consulting

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#### **Executive Summary**

#### Introduction and Year 1 Savings Offset Payments

The Dirigo Health Reform Act includes a provision for a Savings Offset Payment (SOP), designed to reflect the impact of various Dirigo and Dirigo-related savings initiatives to reduce the rate of growth in the health care system in the State of Maine (Maine). The Dirigo Health Reform Act was approved by the Governor of Maine in June 2003. The first year of operations began June 2003 and concluded May 2004, with the first year of enrollment commencing January 2005 and ending December 2005. Per the terms of the Dirigo Health Reform Act, the Year 1 Savings Offset Payment (SOP) methodology had to cover multiple time periods to address the various time periods associated with each of the Year 1 initiatives. The process to determine the savings methodologies began in the fall of 2004 and continued into 2005. The final savings methodologies were determined in October 2005. Please refer to the final report of the Superintendent of the Bureau of Insurance at http://www.state.me.us/pfr/ins/ins05700Dirigo.htm.

The Year 2 savings methodologies and SOP amount are required to be completed by April 1, 2006, in compliance with Title 24-A M.R.S.A §6913. However, not all the relevant data necessary to calculate the Year 2 savings amounts and SOP will be available until July 1, 2006, at the earliest. The unavailability of this data makes it impossible to determine the savings amount at this time; however, the methodologies for calculation can be established.

Mercer Government Human Services Consulting (Mercer) has been engaged by the Dirigo Health Agency (DHA) to develop the Year 2 savings methodologies and ensure that they are consistent, as reasonable as possible given the absence of data, and are structured to adequately measure the impact of the initiatives on the rate of growth in the health care system in the State. In general, Mercer relied upon the Year 1 methodologies

reviewed and approved by the Superintendent of Insurance (Superintendent). Where appropriate, Mercer made adjustments to the methodology in Year 2 to improve its ability to determine the impact of the Dirigo initiatives upon the health care system in the State.

Mercer is not an expert in Medicare Cost Reports (MCRs) or the State's Certificate of Need/Capital Investment Fund (CON/CIF) process. As a result, for the Year 2 hospital savings initiatives, Mercer relied on the work done by Dr. Nancy Kane of the Harvard School of Public Health during the Year 1 calculations, as well as State employees identified by the State as having particular expertise in MCRs. For the Year 2 CON/CIF initiatives, Mercer relied on the work of State employees identified by the State as having particular expertise in CON/CIF initiatives. For savings initiatives using the MCRs and CON/CIF data, Mercer and the State experts worked collaboratively to determine a reasonable methodology for determining what savings, if any, resulted from the Dirigo initiatives. Mercer was also hired by the DHA to compile the savings methodologies, summarize them into a single report, and present that report to the DHA and the DHA Board of Directors (Board) as part of an adjudicatory hearing process. This report represents that summary. The Board then has the responsibility to determine the methodology and actual SOP amounts forwarded to the Superintendent of Insurance for final review.

The following savings methodologies were developed using the following standards:

- actuarial science best practices;
- reasonableness of the assumptions used in the methodologies; and
- adherence to the guidelines provided by the Superintendent in regards to the Year 1 methodologies.

Mercer developed the methodologies with the intent that readily available, industry-standard data sources would be used for the calculations. The following summary of initiatives and the savings methodologies outlines the methodology that will be employed when the necessary data becomes available.

Cost Savings Initiatives — Year 2 Methodology

#### **Hospital Savings Initiatives**

This section outlines the voluntary targets that were established for hospitals as a way to generate savings to payers and to the health care system. For hospital fiscal years ending in 2004 and 2005, the Maine Hospital Association (MHA), acting on behalf of its member hospitals, agreed to a voluntary limit for increases in cost per case-mix adjusted discharge (CMAD) of 4.5 percent. (See the attached MHA newsletter)

#### Cost per Case-Mix Adjusted Discharge

CMAD measures the cost of inpatient and outpatient services provided by hospitals and their subsidiaries. Reducing the rate of increase in the cost of services reduces the need for payer rate increases and results in savings to the entire health care system.

The CMAD methodology for savings determination combines hospital fiscal year (HFY) data for each hospital to adjust each hospitals' cost per discharge to a State fiscal year (SFY) basis. Appropriate revenues and expenses will be summed across all hospitals to determine system-wide revenues and expenses. Then Statewide CMAD figures for SFY00 through SFY05 will be determined. A projected system-wide SFY03 will be estimated by projecting the SFY00 CMAD forward, using the hospital market basket index (HMBI) for each year. A pre-Dirigo annual rate of growth in CMAD exclusive of HMBI increases will be determined using SFY00 and SFY03 CMAD information. A projected SFY05 CMAD will be determined using the actual SFY03 CMAD, HMBI trends, and the annual rate of growth above HMBI inflation. SFY05 projected Statewide CMAD will be compared with the actual Statewide SFY05 CMAD. This final aggregate savings amount, positive or negative, will be multiplied by the total Maine hospital CMAD in SFY05 to determine the final savings amount. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

As of the writing of this methodology report, all of the data for the CMAD calculation is not available, so savings amounts cannot be calculated at this time.

#### **Uninsured Savings Initiatives**

The uninsured savings stem from the reduction in bad debt (BD) and charity care (CC) that will result from taking previously uninsured and under-insured individuals and providing them with health coverage. As these individuals become insured, hospitals and other health care providers will no longer incur the BD and CC associated with their health care and will not need to cost-shift to private payers to cover the cost of their previously non-reimbursed health care. In addition, uninsured savings can result from a "woodwork effect" (WW Effect) due to expansions in eligibility. These expansions in eligibility can come from either new MaineCare enrollment or new MaineCare eligibility. The "WW Effect" occurs when major health care reform initiatives are introduced, causing people to "come out of the woodwork" to enroll. Increased enrollment in the new program and an overall increase in the Medicaid program enrollment take place due to the increased publicity and awareness of the value of health insurance.

#### **Bad Debt and Charity Care Savings**

The methodology for determining savings for the uninsured and under-insured will require determining the amount of BD and CC costs attributable to previously uninsured

and under-insured that are now in DirigoChoice. These amounts will be converted to a cost basis and adjusted for BD/CC due to cost-sharing. The average per member per month (PMPM) cost for those that were both previously uninsured and under-insured will be calculated. Member months (MMs) will be determined and the PMPM costs adjusted for those that used hospital-based services. Savings are determined by multiplying the PMPM by the estimated number of MMs of the previously uninsured or under-insured. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

#### MaineCare Adults Expansion

The methodology to determine the savings for this initiative begins with determining the increase in enrollment, measured in MMs, in the MaineCare Adults Expansion. This will be combined with the PMPM cost for the uninsured, adjusted for cost-sharing differences, and those differences established in the assumed future BD/CC expenditures. The product of these differences and the enrollment increases will account for the savings. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

#### Woodwork Effect Savings

The methodology to determine the savings derived from the "WW Effect" begins with determining the portion of increase in enrollment, measured in MMs, in the overall MaineCare program that is attributable to Dirigo. This will be combined with the PMPM cost for the uninsured, adjusted for cost-sharing differences, and those differences established in the assumed future BD/CC expenditures. The product of these differences and the enrollment increases will account for the savings. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

As of the writing of this methodology report, all of the data for the uninsured calculations are not available, so savings amounts cannot be calculated at this time.

## Certificate of Need and Capital Investment Fund Savings Initiatives

The methodology for determining cost savings will need to determine the reductions in spending for hospital and non-hospital infrastructure that resulted from the CON moratorium and CIF limits. CIF amounts are imposed by calendar year (CY); however, the methodology for the savings calculations will be determined by SFY in compliance with the other savings determinations and the CON.

The methodology will begin with categorizing CON/CIF projects into pre- and post-Dirigo time frames. An average cost per project will be determined and an estimated

average third year operating cost per project in the post-Dirigo time period established. The average cost per project will then be applied to the ratio of projects by project milestone and savings calculated. The project milestone ratio will be determined by comparing the projects at each milestone in the CON/CIF process in the pre-Dirigo time period to the post-Dirigo time period. The addition of the present value of the amounts saved on each project will represent the savings generated from the CON/CIF initiatives. A similar methodology will be followed for non-hospital CON projects. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

As of the writing of this methodology report, all of the data for the CON/CIF calculations are not available, so savings amounts cannot be calculated at this time.

#### **Health Care Provider Fee Savings Initiatives**

Hospitals and other health care providers must seek to meet their annual financial requirements using a variety of funding sources. Over the long term, differences between financial requirements and payments by various payers may be shifted to the private sector payers, whose rates are negotiable (unlike the public sector — Medicare and Medicaid — where rates are determined by the public payers), resulting in higher rate increases to private payers. The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives. Therefore, the need for cost increases to other payers will be reduced when this additional cash is received by hospitals and physician providers, resulting in savings to the system.

#### Hospital Fee and Physician Fee Initiatives

In accordance with the direction of the Superintendent, the hospital fee initiative methodology for calculating savings will calculate the sum of the time value of borrowed funds for the budgeted increase in State's Prospective Interim Payments (PIP) for CY06. The physician fee initiative methodology, in accordance with the direction of the Superintendent, will determine the available savings as based on budgeted State payments to eligible physicians during CY06.

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#### Introduction — Savings Offset Payment Methodology Year 2

#### Overview and Background

Chapter 87 of Title 24-A of the Maine Insurance Code, Dirigo Health outlines the primary requirements and guidelines for operation and management of Dirigo Health. One of the key requirement calls for measuring the aggregate cost savings on an annual basis that result from Dirigo and its various directly and indirectly related components. Per the terms of the Dirigo Health Reform Act, the Year 1 Savings Offset Payment (SOP) methodology had to cover multiple time periods to address the various time periods associated with each of the Year 1 initiatives. The process to determine the savings methodologies began in the fall of 2004 and continued into 2005. The final savings methodologies were determined in October 2005. Please refer to the final report of the Superintendent of the Bureau of Insurance's at http://www.state.me.us/pfr/ins/ins05700Dirigo.htm.

The Year 2 savings methodologies and SOP are required to be completed by April 1, 2006, in compliance with Title 24-A M.R.S.A §6913. However, all of the relevant data necessary to calculate Year 2 savings SOP will not be available until July 1, 2006, at the earliest. The unavailability of this data makes it impossible to determine the savings amount and SOP at this time; however, the methodologies for calculation can be established.

Mercer Government Human Services Consulting (Mercer) has been engaged by the Dirigo Health Agency (DHA) to develop the Year 2 savings methodologies and ensure that they are consistent, as reasonable as possible given the absence of data, and are structured to adequately measure the impact of the initiatives on the rate of growth in the

health care system in Maine. In general, Mercer relied upon the Year 1 savings methodologies reviewed by and approved by the Superintendent of Insurance (Superintendent). Where appropriate, Mercer made adjustments to the savings methodologies in Year 2 to improve its ability to determine the impact of the Dirigo initiatives upon the health care system in the State of Maine (Maine).

Mercer is not an expert in Medicare Cost Reports (MCRs) or the State's Certificate of Need/Capital Investment Fund (CON/CIF) process. As a result, for the Year 2 hospital savings initiatives, Mercer relied on the work Dr. Nancy Kane, a professor of Management at the Harvard School of Public Health, completed during the Year 1 calculations, as well as State employees identified by the State as having particular expertise in MCRs. For the Year 2 CON/CIF initiatives, Mercer relied on the work of State employees identified by the State as having particular expertise in CON/CIF. For savings initiatives using the MCRs and CON/CIF data, Mercer and the State experts worked collaboratively to determine a reasonable methodology for determining what savings, if any, resulted from the Dirigo initiatives. Mercer was also hired by the DHA to compile the savings methodologies, summarize them into a single report, and present that report to the DHA and the DHA Board of Directors (Board) as part of an adjudicatory hearing process. This report represents that summary. It is then up to the DHA Agency and Board to determine the savings methodologies and savings amount to be forwarded to the Superintendent of Insurance.

The savings methodologies in this report were developed using the following standards:

- actuarial science best practices;
- reasonableness of the assumptions used in the methodologies; and
- adherence to the guidelines provided by the Superintendent in regards to the Year 1 methodologies.

Mercer developed the methodologies with the intent that readily available, industry-standard data sources would be used for the calculations.

#### Year 2 Savings Calculation Methodology

As indicated above, the relevant data necessary to calculate Year 2 savings amount and SOP will not be available until July 1, 2006 at the earliest. The unavailability of this data makes it impossible to determine the savings at the time of this report; however, the methodologies for calculation can be created. The following initiatives are included.

#### **Initiatives for Cost Savings Measurement**

- Hospital Savings Initiatives
  - Hospital System Cost Per Case Mix-Adjusted Discharge (CMAD)
- Uninsured Savings Initiatives

- Uninsured Reduction of Bad Debt (BD) and Charity Care (CC)
- Under-Insured Reduction of BD and CC
- MaineCare Eligibility (MaineCare Adult Expansion) Enrollment
- MaineCare Increased (MaineCare Woodwork Effect) Enrollment
- Uninsured Private Woodwork (Private WW) Enrollment
- Certificate of Need (CON) and Capital Investment Fund (CIF) Savings Initiatives
  - Hospital CON Moratorium and CIF limits
  - Non-Hospital CON Moratorium and CIF limits
- Health Care Provider Fee Savings Initiatives
  - Hospital Fee Initiatives
  - Physician Fee Initiatives

The Year 1 savings methodology included a calculation of the savings achieved by hospitals through a voluntary Consolidated Operating Margin (COM) limit and for insurance carriers through a Voluntary Underwriting Gain (VUG) limit. There has been no legislation re-authorizing the COM or VUG limits, nor have hospitals or carriers voluntarily agreed to continue the COM or VUG limits, respectively. Therefore, there is no COM or VUG calculation in the Year 2 savings methodology.

#### **Methodology and Assumptions**

#### **Guiding Principles**

In developing the methodology for calculating the Year 2 aggregate measurable savings, the following principles guided our process:

- Initiatives will be related to the Dirigo Health Reform Act, consistent with Public Law (PL) 2003, Chapter 469 and the methodologies themselves must be consistent with PL 2003 Chapter 469.
- To the extent possible, methodologies for Year 2 will be consistent with the guidelines provided by the Superintendent in regards to the Year 1 methodologies. Where appropriate, Mercer made changes to the guidelines suggested by the Superintendent and noted our changes accordingly.
- Initiatives are primarily voluntary. It is the role of the marketplace to voluntarily comply with savings targets and to recapture savings in price negotiations.
- Data sources, when available, must be readily available, verifiable and auditable, and to the extent possible, used for multiple purposes to ensure the accuracy of the underlying data.
- The savings, once calculated, should not be overstated, nor should they be understated: the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system.
- The methodology for savings calculations must be transparent, meaning the savings are calculated using the data available, the methodologies as best as

- possible laid out in this report, and savings amounts verified through worksheets contained in a final report when data is available.
- When calculated, the savings will be used to sustain DirigoChoice at no additional costs.

#### **Organization of Report and Data Availability**

The remainder of this document contains chapters that outline and explain each of the above initiatives. The methodologies for cost savings that are presented here have been developed in the absence of much of the necessary data. As a result, the final methodologies may require some adjustments when the final data is utilized.

The following table depicts the data availability by initiative at this time.

**CMAD\*** Data Elements

Data Elements	Data Source	Time Period	Date Available	
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available	
Discharges and Case-Mix Index by Hospital	Maine Health Data Organization	HFY99 to HFY05	Currently Available	
Discharges and Case-Mix Index by Hospital	Maine Health Data Organization	HFY ending 9/30/05 and 12/31/05	July 2006	
Expense and Revenue Reports by Hospital	MCRs	HFY99 to HFY05	Currently Available	
Expense and Revenue Reports by Hospital	MCRs	HFY ending 9/30/05 and 12/31/05	July 2006	
Hospital Tax Allocation	Audited Financial Statements and State/MHA Information	HFY99 to HFY04	Currently Available	
		HFY ending 9/30/05 and 12/31/05	July 2006	

<sup>\*</sup>Pending request new/updated filings after 7/05 for the period HFY99–04. Pending request to obtain Medicare Cost Reports currently available for HFY05 and HFY06.

#### MaineCare Uninsured/Under-Insured/WW Effect Data Elements

Data Elements	Data Source	Time Period	Date Available
нмві	Global Insight/DRI	SFY00 to CY06	Currently Available
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo	DirigoChoice Member Survey — Updated	1/1/05 to 6/30/05	Currently Available
Enrollment in MaineCare Adult Expansions	MaineCare Enrollment Reports	SFY04 to SFY06	July 2006

#### **CON/CIF Data Elements**

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
CON/CIF Project Filings and Cost Information	State CON Department	SFY99 to CY05	Currently Available
CON/CIF Project Filings and Cost Information	State CON Department	1/1/06 to 6/30/06	July 2006

**Hospital Fee Initiatives Data Elements** 

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Historical Settlement Amount — Paid 9/30/2005	l ·	Paid through 9/30/2005	Currently Available
Current Settlement Amount — Budgeted	State Budget	SFY06 and SFY07	Currently Available
Increase in PIP Payments — Budgeted	State Budget	CY06	Currently Available

**Physician Fee Initiatives Data Elements** 

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Increase in Fee Schedule Payments — Budgeted		CY06	Currently Available

**Data Elements Applicable to Multiple Initiatives** 

Data Elements	Data Source	Time Period	Date Available
Short-Term Interest Rate	1		July 2006 for midpoint of CY06

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## **Hospital Savings Initiatives**

#### Introduction

This section outlines the voluntary targets that were established for hospitals to generate savings to payers and to the health care system. CMAD measures the cost to the hospital of services in hospitals and their subsidiaries. Reducing the rate of increase in the cost to the hospital of services reduces the need for hospitals to increase the rates they charge to payers and results in savings to the entire health care system.

## Year 1 Methodology

#### Cost per Case-Mix-Adjusted Discharge

Dr. Nancy Kane, a professor of Management at the Harvard School of Public Health, calculated the CMAD savings calculation for Year 1. The following is a brief description of the savings methodology she employed to estimate Year 1 savings for CMAD voluntary target. For a more complete description of Dr. Kane's Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).

To determine if savings resulted from the voluntary CMAD target, it was necessary to first blend each hospital's fiscal year (HFY) data together to create a cost per discharge figure for each hospital on a state fiscal year 2000 (SFY00) basis. Then each hospital's projected SFY03 cost per discharge was estimated from SFY00 costs by trending forward the SFY00 cost per discharge amounts by the annual HMBI increases. The projected SFY03 costs were compared to the actual SFY03 (blended) costs to determine each

hospital's cost per discharge growth rate above inflation. SFY04 CMAD was estimated using a hospital's cost growth rate above inflation and compared to the hospital's actual SFY04 (blended) cost per discharge. Savings were calculated when the difference between the SFY04 estimated cost per discharge and the actual SFY04 (blended) cost per discharge was positive. Summing this cost per discharge savings across all discharges and all hospitals yielded total savings for the voluntary CMAD target.

There are 4 potential scenarios where savings could have occurred in Year 1 for a hospital, using the Year 1 voluntary CMAD limit of 3.5% Mercer's approach in Year 1 was conservative and only estimated savings derived from the first two scenarios:

- 1. Hospital baseline trend was above 3.5% and SFY/04 trend was below the baseline. Positive savings can be directly measured in Scenario #1.
- 2. Hospital baseline trend was below 3.5% and SFY04 trend was below the baseline. Positive savings can be directly measured in Scenario #2
- 3. Hospital baseline trend was above 3.5% and SFY04 trend was above the baseline. For positive savings to be measured in Scenario #3, an indirect counter-factual analysis would have been necessary to determine if the SFY04 trend would have been higher in the absence of Dirigo.
- 4. Hospital baseline trend was below 3.5% and SFY04 trend was above the baseline. For positive savings to be measured in Scenario #4, an indirect counter-factual analysis would have been necessary to determine if the SFY04 trend would have been higher in the absence of Dirigo.

Table 1 depicts the methodology used to determine the impact of voluntary CMAD limits in Year 1.

Table 1. CMAD - Year 1 Methodology

Sávings	SFY04 trend is lower than baseline trend	SFY04 trend is higher than baseline trend
Positive	A) Scenarios 1 and 2 above	C) Normally occurring fluctuations in CMAD
Negative	B) Normally occurring fluctuations in CMAD	D) Scenarios 3 and 4 above

Table 2 compares the Superintendent's guidelines for the Year 1 methodology to Mercer's Year 1 methodology.

Table 2. CMAD - Comp	Table 2. CMAD - Comparison of Year 1 Methodologies			
Methodology	Comparison			
Mercer's Year 1 Methodology	Mercer's Year 1 methodology estimated savings only from Box A; positive savings as a result of measurable reductions in CMAD. The testimony during the Year 1 adjudicatory hearing clearly established that Dirigo was the primary driver of positive savings in Box A, representing Scenarios 1 and 2. The Testimony also clearly established that Dirigo was <i>not</i> the primary driver of negative savings in Box D, representing Scenarios 3 and 4.			
	In fact, the testimony established that nothing in the Dirigo legislation would cause an increase in costs (and thus negative savings) as measured by Box D. Mercer assumed that, at a minimum, a similar relationship existed between Boxes B and C. Mercer assumed, at a minimum, the savings component in Box B (which is negative overall) would be at least as large in magnitude as the savings component in Box C (which is positive overall).			
	This assumption was borne out as reasonable, as testimony clearly established that Dirigo was the primary driver behind positive savings in the system and had no impact on negative savings. Thus, Mercer's methodology, based on positive savings from Box A and implicitly accounting for random fluctuations by assuming Boxes C and D at a minimum cancel each other out, was reasonable.			
Superintendent's Year 1 Methodology	The Superintendent was concerned with controlling for normally occurring fluctuations and so included both Box A and D in an attempt to control for those fluctuations and determine savings due to Dirigo. The Superintendent's methodology effectively provides equal weights to the Dirigo impacts in Box A and Box D. However, as noted above, the testimony clearly showed this was not the case — Dirigo was the driver in Box A but had no impact on Box D.			
	Thus, the Superintendent's methodology of netting Boxes A and D unnecessarily reduces the savings attributed to Dirigo, contrary to the testimony, in an attempt to control for normally occurring fluctuations in CMAD.			

## Year 2 Methodology and Data Sources

#### Cost per Case-Mix Adjusted Discharge

Using the Superintendent's decision on Year 1 savings as guidance, Mercer has modified the CMAD savings methodology for Year 2.

#### Methodology

Table 3 describes Mercer's Year 2 CMAD methodology based on input from the Superintendent.

Table 3. CMAD - Description and Comparison of Mercer's Year 2 Methodology to Year 1

Methodology	Description and Comparison to Year 1
Mercer's Year 2 Methodology	To address the Superintendent's concern about Mercer's Year 1 methodology not factoring in normally occurring fluctuations in CMAD, Mercer has designed a methodology for Year 2 that includes all four Boxes: A, B, C, and D. In Mercer's Year 2 methodology, we apply Year 1's approach to determining individual hospital CMAD experience and then go a step further in Year 2 by summing all hospitals' experience to determine a Statewide aggregate CMAD pre- and post-Dirigo.
	This additional step of summing all of the hospitals' individual CMAD experience includes <i>all</i> of the experience — Boxes A, B, C, and D. Mercer's Year 2 methodology for CMAD addresses the concerns raised by the Superintendent by controlling not only for positive savings (Box A), but also for normally occurring fluctuations (Boxes B and C), as well as negative savings (Box D).
	Finally, to address a concern raised by the Superintendent about determining savings across inconsistent time periods, Mercer will apply an interest factor to adjust the savings to a consistent present value.

Below is the process Mercer will take in order to determine if there are overall aggregate CMAD savings in Year 2:

- 1. Combine HFY data for each hospital as necessary to put all hospitals on a SFY basis:
- 2. Sum the appropriate revenues and expenses across all hospitals to determine system-wide revenues and expenses, then calculate Statewide CMAD figures for SFY00 through SFY05;
- 3. Project the SFY03 CMAD system-wide from the SFY00 CMAD trended forward using the HMBI for each year to SFY03; compare this projected SFY03 CMAD to the actual SFY03 CMAD and calculate the pre-Dirigo annual rate of increase in beyond inflation in the HMBI;

- 4. Project the SFY05 CMAD using the actual SFY03 CMAD, HMBI trends, and the pre-Dirigo annual rate of growth above inflation;
- 5. Compare the projected Statewide SFY05 CMAD with the actual Statewide SFY05 CMAD; savings are calculated as the difference of the projected system-wide figure compared to the actual;
- 6. Multiply the savings per CMAD by the total Maine hospital CMAD in SFY05 to arrive at our final savings number; and
- 7. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

#### Data

Table 4 below describes the data required to determine the impact of the Year 2 voluntary limit on CMAD.

Table 4. CMAD\* Data Elements

Table 4. CMAD" Data Elements			
Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Discharges and Case-Mix Index by Hospital	Maine Health Data Organization	HFY99 to HFY05	Currently Available
Discharges and Case-Mix Index by Hospital	Maine Health Data Organization	HFY ending 9/30/05 and 12/31/05	July 2006
Expense and Revenue Reports by Hospital	MCRs	HFY99 to HFY05	Currently Available
Expense and Revenue	MCRs	HFY ending 9/30/05 and 12/31/05	July 2006
Hospital Tax Allocation	Audited Financial Statements and State/MHA Information	HFY99 to HFY04	Currently Available
Hospital Tax Allocation	Audited Financial Statements and State/MHA Information	HFY ending 9/30/05 and 12/31/05	July 2006

<sup>\*</sup>Pending request new/updated filings after 7/05 for the period HFY99–04. Pending request to obtain Medicare Cost Reports currently available for HFY05 and HFY06.



## **Uninsured Savings Initiatives**

#### Introduction

In this section we will discuss the potential for uninsured and under-insured savings due to the reduction in BD and CC and the "WW Effect" for MaineCare individuals. The uninsured savings stem from the reduction in BD and CC that will result from taking previously uninsured and under-insured individuals and providing them with health coverage. As these individuals become insured with credible coverage, the hospitals and other health care providers will no longer incur the BD and CC associated with their health care and, therefore, will not need to cost-shift to private payers to cover the cost of their previously non-reimbursed health care.

The "WW Effect" happens when major health care reform initiatives are introduced, causing people to "come out of the woodwork" to enroll. In addition to increased enrollment in the new program, states see an increase in the Medicaid program due to the increased publicity and awareness of the value of health insurance. The Dirigo statute states savings are to be measured due to "...any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." Increased enrollment can be due to eligibility changes, such as the MaineCare Adult Expansion group (150 – 200% of Federal Poverty Level) that began enrollment in Spring of 2005, or increased enrollment can due to the number of MaineCare eligibles increasing in general as a result of Dirigo.

The "WW Effect" on the private insurance market will be analyzed once data is available.

## Year 1 Methodology

In the Year 1 savings calculation, Mercer estimated the savings generated by those people that were once uninsured or under-insured and now insured under Dirigo. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).

To determine if there were savings from the uninsured and under-insured receiving health insurance due to Dirigo, Mercer projected the BD/CC PMPM costs, adjusting for those who enroll into Dirigo in the first year and reflecting their relative risk, and multiplying by those that are now in Dirigo who used to be incurring the BD/CC costs.

The MaineCare "WW Effect" was calculated to measure the savings generated due increased MaineCare enrollment as a result of the publicity around the Dirigo program. This was calculated in manner similar to the uninsured savings calculation. Any "WW Effect" on the private insurance market was postponed until data was available.

#### Year 2 Methodology and Data Sources

## Uninsured and Under-insured: Reduction of Bad Debt and Charity Care

Using the methodology approved by the Superintendent for the Year 1 SOP calculation as a guide, Mercer will determine savings in Year 2 using the following methodology.

#### Methodology

- Determine the amount of BD and CC costs attributable to previously uninsured and under-insured individuals that are now in DirigoChoice. Using the above data, BD and CC spent in hospitals and spent with other providers will be added to determine a total BD and CC dollar amount. Hospitals report data on differing HFYs, so adjustments will be made to put all data on a consistent CY time period. This will be further split by the uninsured and under-insured. HMBI trend will be applied to these costs to estimate BD and CC in CY06, assuming the absence of the DirigoChoice program;
- 2. Adjust the BD and CC dollar amount in Step 1 from a hospital charges basis to convert it to an estimated cost basis using the assumption from information in the MCRs. An additional adjustment will be made to account for possible BD/CC due to cost-sharing. That is, providers who render services to individuals with higher deductible plans still face the risk of not being able to collect in the entirety for services they perform.

- 3. Calculate the average PMPM cost for those that were previously uninsured and under-insured by using BD and CC costs developed in Step #1 and Step #2 and dividing by MMs of those uninsured and those under-insured. The MMs will be determined by taking the uninsured and under-insured individuals and multiplying by 12 months.
- 4. Adjust the PMPM calculated in Step #3 by applying an adjustment factor based on the Claims Probability Distribution Table for those that used hospital-based services, previously incurring BD and CC.
- 5. Multiply the PMPM in Step #4 by the estimated MMs of those previously uninsured or under-insured to arrive at savings.
- 6. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

#### Data

Table 5 describes the data elements that will be necessary to determine the impact of the uninsured savings initiatives upon the health care system in Maine.

Table 5. Uninsured/Underinsured Data Elements

Data Elements	Data Source	Time Period	Date Available
HMBI	Global Insight/DRI	SFY00 to CY06	Currently Available
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo	DirigoChoice Member Survey — Updated	1/1/05 to 6/30/05	Currently Available
Enrollment in MaineCare	MaineCare Enrollment Reports	SFY04 to SFY06	July 2006

#### **MaineCare Adult Expansion**

To determine the impact of the MaineCare Adult Expansion, Mercer will use the methodology below.

#### Methodology

- 1. Determine increase in enrollment in the MaineCare Adult Expansion;
- 2. Using the MMs from Step #1 and the PMPMs developed above for the uninsured, adjust for cost-sharing differences and differences in assumed future BD/CC expenditures;
- 3. Calculate savings by multiplying Step #1 and Step #2 together; and
- 4. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

#### Data

The source data used in this calculation will be most of the same source data used in the uninsured and under-insured calculations. An additional data source will be used to calculate the MaineCare net change in enrollment in the time frames used. Month by month counts of MaineCare enrollees by eligibility category will be prepared by the Institute for Health Policy, Edmund S. Muskie School of Public Service, University of Southern Maine. Also, a cost-to-charge ratio developed from MCR information will be used.

Table 6. MaineCare Adult Expansion Data Elements

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available

Data Elements	Data Source	Time Period	Date Available
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo		1/1/05 to 6/30/05	Currently Available
Enrollment in MaineCare Expansions	1	SFY04 to SFY06	July 2006

#### **MaineCare Woodwork Effect**

To determine the portion of the increase in MaineCare enrollment due to the Dirigo program, Mercer will use the methodology detailed below.

#### Methodology

- 1. Determine increase in enrollment in the MaineCare prior to Dirigo and compare that rate of increase after Dirigo; determine if Dirigo has impacted the rate of enrollment growth and if so, convert that impact to an estimated annual MM figure based on annual growth rates;
- 2. Using the MMs from Step #1 and the PMPMs developed above for the uninsured, adjust for cost-sharing differences and differences in assumed future BD/CC expenditures;
- 3. Calculate savings by multiplying Step #1 and Step #2 together; and
- 4. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

#### Data

The source data used in this calculation will be most of the same source data used in the uninsured and under-insured calculations. An additional data source will be used to calculate the MaineCare net change in enrollment in the time frames used. Month by month counts of MaineCare enrollees by eligibility category will be prepared by the Institute for Health Policy, Edmund S. Muskie School of Public Service, University of Southern Maine. Also, a cost-to-charge ratio developed from MCR information will be used.

Table 7. MaineCare WW Effect Data Elements

I ADIE 7. MAINECARE WW Effect Data Elements				
Data Elements	Data Source	Time Period	Date Available	
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available	
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available	
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available	
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available	
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006	
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available	
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available	
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo	DirigoChoice Member Survey C Updated	1/1/05 to 6/30/05	Currently Available	
Enrollment in MaineCare	MaineCare Enrollment Reports	SFY04 to SFY06	July 2006	

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# Certificate of Need and Capital Investment Fund Savings Initiatives

#### Introduction

This section outlines the cost savings that result from the reductions in operation spending. This includes savings from the CON Moratorium and CIF, for both hospitals and non-hospitals. CON and CIF are measures of spending for hospital and non-hospital providers. As this spending is reduced, the need for payer rate increases is reduced: the State imposed a moratorium on spending for new buildings and equipment for one year, starting May 1, 2003, and imposed a limit to all subsequent new spending to an annually adjusted amount within the CIF. CIF amounts are imposed by CY; however, the following savings calculations were determined by SFY in compliance with the other savings determinations and the CON.

## Year 1 Methodology

The methodology for calculating the savings in relation to the CON/CIF initiatives for Year 1 compared the third year operating costs for all projects pre- and post-Dirigo. Using a lag table to show the run-out of project costs over an assumed useful project life of 3 years for all hospital and non-hospital projects, Mercer estimated the savings due to the reduction in projects resulting from the CON moratorium and CIF limitation. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, Dirigo Health Savings Payment: Year 1. Savings Offset Methodology and Calculations, November 2005 (Revised).

## Year 2 Methodology and Data Sources

## Certificate of Need and Capital Investment Fund Savings Initiatives

After reviewing comments made by the Superintendent for the Year 1 savings calculation, and consulting with State CON/CIF staff, Mercer has developed the following methodology for this calculation.

#### Methodology

- 1. Using the data send from the State, separate the CON/CIF projects in pre-Dirigo (07/01/1998-04/30/2003) and post-Dirigo (05/01/2003-06/30/2006).
- 2. Using the third year operating cost from the pre-Dirigo data, determine an average cost per project to use in the savings calculations.
- 3. Apply HMBI trend to the average third year operating cost per project to estimate average third year operating cost per project in the post-Dirigo time period.
- 4. Apply the average cost per project to the differences in the project milestone ratios. The project milestone ratios will be determined by comparing the hospital and non-hospital CON and CIF activity by milestone in the pre-Dirigo time period to the post-Dirigo time period. The savings will be estimated on a milestone-by-milestone basis.
- 5. Adjust each milestone savings estimate calculated in Step #4 to a present value savings dollar amount. The addition of the present value of each savings will be the savings generated from the CON/CIF initiatives. A similar methodology will be followed for non-hospital CON projects.
- 6. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

#### Data

As it becomes available, the State will supply data on the volume of Letters of Intent, Technical Assistance Sessions, Applications, and Approvals for all hospital and non-hospital CON projects for the time period 07/01/1998–06/30/2006. We will also use the HMBI trends to project the data into future time periods.

Table 8. CON/CIF Data Elements

Data Elements	Data Source	Time Period	Date Available
нмві	Global Insight/DRI	SFY00 to CY06	Currently Available

Data Elements	Data Source	Time Period	Date Available
CON/CIF Project Filings and Cost Information	State CON Department	SFY99 to CY05	Currently Available
CON/CIF Project Filings and Cost Information	State CON Department	1/1/06 to 6/30/06	July 2006

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## **Health Care Provider Fee Savings Initiatives**

This section outlines the cost savings from reductions in cost shifting that result from increased funding to hospitals and other providers. Hospitals and other health care providers must meet their annual financial requirements using a variety of funding sources. Over the long term, differences between financial requirements and payments by various payers may be shifted to the private sector payers, whose rates are negotiable (unlike the public sector — Medicare and Medicaid — where rates are determined by the public payers), resulting in higher rate increases to private payers. The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives, to recognize differences identified by the Maine Hospital Commission in its review of the funding of the Medicaid program. Therefore, the need for cost increases to other payers will be reduced when this additional cash is received by hospitals and physician providers, resulting in savings to the system.

## Year 1 Methodology

## **Hospital Fee Initiatives**

The methodology for calculating the savings in relation to the hospital fee initiatives for Year 1 included determining the amount of additional funding and the time value of money involved with getting the money earlier than expected. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).

#### Physician Fee Initiatives

The methodology for calculating savings for the increase in the physician Medicaid fee schedule was developed by reviewing payments to be made 07/01/05–12/31/06. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).

## Year 2 Methodology and Data Sources

#### Hospital and Physician Fee Savings Initiatives

To determine the impact of the hospital and physician fee initiatives, Mercer will use the methodology below for Year 2.

#### Methodology

- 1. Confirm hospital Prospective Interim Payment (PIP) increases and increased physician payments to be paid in CY06.
- 2. Calculate the time value of receiving the PIP increases early so hospitals do not have to borrow or use other funds. Use an updated interest rate to reflect the appropriate time periods.
- 3. Calculate the amount of additional physician money available. Add #2 and #3 to determine total savings for this initiative.
- 4. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

#### Data

Table 9.a. Hospital Fee Initiative Data Elements

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Historical Settlement Amount — Paid 9/30/2005	State Budget	Paid thru 9/30/2005	Currently Available
Current Settlement Amount — Budgeted	State Budget	SFY06 and SFY07	Currently Available
Increase in PIP Payments — Budgeted	State Budget	CY06	Currently Available

Table 9.b. Physician Fee Initiative Data Elements

Data Elements	Data Source	Time Period	Date Available
нмві	Global Insight/DRI	SFY00 to CY06	Currently Available
Increase in Fee Schedule Payments — Budgeted	l .	CY06	Currently Available

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